Managing Crisis Situations in the Home and Community

Curriculum and Instructor's Curriculum Guide

Wellness Project Curriculum

Welcome!

The goal of this curriculum is twofold. It is intended to increase DSP skills in effectively providing support to consumers in crisis situations, and also in recognizing potential crisis situations and averting them through proactive positive support.

The IRC Wellness Curriculum was the result of an inter agency collaboration. The IRC Wellness Project was funded by a Wellness Grant from DDS. The following agencies and individuals contributed to the development and presentation of the curriculum:

Inland Regional Center;
Pathway, Inc.;
Riverside County Emergency Treatment Services;
Colton, Redlands, Yucaipa ROP;
EMQ Children and Family Services;
Eugene Hernandez, Ret. Police Chief;
Pravin Kansagra M. D.;
Art Medrano, Psy.D.;
Kari Burroughs, Consumer Advocate;
Area Board 12 and
Nancy Alexander, Project Coordinator.

GENERAL CURRICULUM NOTES

The curriculum is divided into six classes. Class Competencies were developed for each class, and are presented on page 8 of this guide following the Class Titles. Each class consists of some combination of the following to achieve those objectives: interactive presentations in the form of PowerPoint presentations , experiential exercises and role plays. With the exception of Class 1 - Value Systems and Cultural Awareness, all materials to duplicate the course curriculum are provided. To duplicate Class 1 as presented in this pilot will require the purchase of two productions from the Tools for Change series from the ACT Self Advocacy Resource Network. These productions are "Changing Attitudes" and "Saints, Sinners and Special People-Understanding the Moral View of Disability." Unless otherwise noted in the Curriculum Notes for each class, all materials may be obtained from Disability Resources @www.disabilitytraining.com.

. The Curriculum Presentation Notes consist of Power Point Slide Notes, Instructor Notes and actual Presentation Commentary. Of course, commentary may be adjusted per individual instructor.

The curriculum was piloted in trainings with DSP employed in ARM Level 3 and 4 residential facilities in Riverside County beginning in September, 2007. It was modified based on feedback obtained during those trainings.

The first pilot trainings were presented to large groups of up to 75 in each class, in a one class per month format over six months.

The second pilot trainings consisted of two classes per month with a maximum of 15 people in each class. The smaller class format was a better fit for the interactive curriculum. 20 students per class would provide 4 groups with 5 students in each group, which would probably represent a near ideal arrangement for the curriculum .

When presented in the pilot stage, the large group classes were 4 hours each, and classes with 15 participants and fewer were scheduled for 3 hours with the exception of class 2. Class 2 requires 4 hours to cover the content whatever the group size.

This curriculum should be considered an ongoing work. The specific role plays and interactive scenarios provided may be changed or substituted, based upon the unique needs and experiences of a participant group.

The entire curriculum and this guide are presented in PDF.

The approved grant proposal identified an interactive curriculum that would be at least 75% experiential in 'real life' simulated interactions. Ultimately, the curriculum provides approximately 80% participant interaction, with approximately 50% spent in role plays. To help reduce the 'fear factor' many people have in response to participation in role plays, active participation is introduced immediately in the first class with participation and interaction in the established small groups. This was designed to build comfort for individuals who may be hesitant to be in front of large groups. The interaction in front of the larger group is gradually introduced by having small groups interact at their tables, and within the group choose their method for presenting their group findings to the entire class. This allows those individuals to be involved in the process and contribute to the outcome, while building comfort and confidence which will be tapped later in the curriculum when all course participants will re requested to actively participate in the role plays.

Following the Slide and Presentation Notes for the Curriculum is the list of resources utilized in developing the curriculum for all the classes in the course. Most of the material was utilized for reference in preparing the curriculum content. Content from the Universal LifeStiles productions of Dr. Tom Pomeranz is more directly quoted and utilized in Classes 1 and 6. Specific terminology and the sequence of the Crisis Development Model from the Crisis Prevention Institute's Non Violent Crisis Intervention are also utilized throughout the course content, as well as materials and information obtained from the Institute for Applied Behavior Analysis 'Positive Practices in Behavioral Support' seminar .

Establishing a level of comfort and rapport among the students is an initial priority.

Staff who work together in a home may arrive together and sit together. The initial exercises include creating more novel groupings of staff and providing the opportunity for active involvement and participation .

Each student on arrival received a playing card (from Ace to 3) and a patterned eraser. Nine different patterns were used, and nine tables were used for groups. Each table matched one eraser. Upon arrival, students could sit anywhere they chose.

Students took turns introducing themselves and showed the playing card they had drawn. They then shared that number (from one to three) of non work related disclosures about themselves with classmates.

After introductions, students were then directed to the table that matched the eraser they received. Once settled in this novel grouping, students were asked to maintain this placement for the duration of the six classes.

Class 1 began with a review of the overall topic and a reiteration of the purpose of the series of six classes.

In the pilot project, the large class sizes dictated that the allotted time of involved interagency staff be used primarily in Classes 3, 4 and 5 to facilitate with the role play groups. They were also utilized to play the roles of the consumers in the role plays in classes 4 and 5. Classes 1, 3, 4, and 5 were developed and presented by the Project Coordinator., with group facilitation provided by ROP staff in Classes 3, 4 and 5. Class 2 was developed and presented by

Pravin Kansagra, M.D. and Claudia Smith, Social Work Supervisor at Riverside County Emergency Treatment Services. Class 6 was developed collaboratively and presented by Art Medrano, Psy.D. and the Project Coordinator.

Smaller class sizes that have 4 groups of 4 or 5 are manageable by one instructor presenting the curriculum and facilitating the role play groups.

Classes 3, 4 and 5 involve the class participants in role plays and scenarios that are inspired by actual incident reports. They are written to highlight a variety of issues for identification and further discussion and role play. The role plays for class 3 were written to exaggerate the missed opportunities for the DSP to recognize anxiety and try to alleviate it, and for the responses of the DSP in the play to be the behavior trigger for the consumer to escalate further.

The class 3 role plays are written with the intent of making the counterproductive DSP actions and responses readily apparent to the participants.. Class members then identify the DSP behavior that contributed to the decline of the situation, and what change they could make to contribute to a positive outcome for the interaction with the consumer(s) through well placed positive supports.

Class participants are able to directly affect whether the consumer experiences a behavioral escalation by changing their proactive and reactive responses.

Participants are identifying in this exercise antecedent situations, antecedent behaviors and environmental modifications that they can make to help make the environment a 'better fit' for the consumer, thereby helping the consumer maintain or regain their self control. These role plays specifically focus on how DSP behavior contributes to the outcome of an interaction, either helping the consumer maintain/regain self control, or contributing to a behavior escalation.

The role plays for classes 4 and 5 primarily present situations that require the staff to 'inherit' situations between consumers that have already developed. The staff must enter the situation when the consumers are already venting or having a verbal altercation. Participants have an opportunity to apply skills in presenting a positive presence, using active listening, using problem solving skills, offering positive if/then limits, and offering positive program reminders and self monitoring instructions. Again, feedback is given from the 'director' for all aspects of the staff response, non verbal, para verbal and verbal response, and whether it is effective in supporting the consumer at that time in preventing further escalation, helping them preserve their personal dignity and maintaining or regaining their self control.

Following the crisis response with director input, the scene is played through implementing any suggestions/recommendations. Participants are then debriefed about how the staff approach/response felt; whether it felt supportive and helped relieve their anxiety.

Following the presentations, the group discusses and problem solves how to make environmental modifications that could prevent the situations from presenting in the future. Participants can also be asked to identify incidental opportunities in the scenarios for teaching skills and/or role modeling in the natural environment, and for opportunities to provide proactive advocacy.

Although the primary emphasis of the course is managing crisis situations in the home and community, proactive positive supports are fundamental to providing meaningful experiences that enrich each person's life. Many crisis situations would be avoided through the enriched life experiences that are provided by the implementation of truly individualized support plans. The curriculum for Class 6 is devoted to making a new start with a consumer; whether returning home from an unplanned psychiatric hospitalization or as part of an assessment of achievement of life quality outcomes. In Class 6, participants were provided data collection and recording materials from the Behavior Assessment Guide published by the Institute for Applied Behavior Analysis.

Nancy Alexander
IRC Wellness Project Coordinator
March, 2009

CLASS TITLES

Class 1 – Cultural Awareness / Value Systems

Class 2 – Psychotropic Medications and the 5150 Process

Class 3 – Recognizing Antecedents

Class 4 – Averting Physical and Chemical Restraints

Class 5 – Diffusing Aggressive Behaviors in the Home and Community

Class 6 – Life After a 5150/Making a New Start

CLASS COMPETENCIES

CLASS ONE: Value Systems and Cultural Awareness

Staff will understand that their values and beliefs can and do affect how they provide support to consumers. They will recognize that they bring something of themselves to each interaction.

Staff will know that all value systems are deeply ingrained through cultural socialization and that self assessment is an ongoing and necessary process in providing services and supports that are objective and promote inclusion, self determination and normalization.

Staff will identify three views of disability: Moral Medical and Civil Rights, the major tenet of each viewpoint

Staff will identify the major tenet of each viewpoint.

Staff will review photographs of people involved in situations depicted as either inclusive and peer typical or not typical, not inclusive. They will identify what makes the situation non inclusive, and identify adaptations to make the situation inclusive and typical.‘

CLASS TWO: Psychotropic Medications and the 5150 Process

Staff will know that the occurrence of mental illness is thought to be higher in the population of people who have developmental disabilities than the general population.

Staff will identify two physical indicators of depression.

Staff will identify two behavioral indicators of depression.

Staff will correctly identify one frequently seen side effect of commonly prescribed psychotropic medications and how staff might help consumers lessen the side effects through focused support and positive supports. (weight gain countered with proactive diet and exercise support

Staff will identify two common reasons for supporting consumers who take psychotropic medications in having regular blood monitoring. (elevated blood sugar, check for level of medication in the blood, check for organ functioning etc.)

When given a written scenario that includes all necessary information to provide an answer, staff will identify the psychiatrically significant behavioral and physical changes to report to the prescribing physician.

Staff will identify correctly the definition of a 5150 as the process of applying for a mental health hold.

Staff will identify who makes the application for a mental health hold.

Staff will know the designated Mental Health facilities in Riverside County.

Staff will know and describe the typical experience (process) that a consumer who is transported on a 5150 experiences.

Staff will, when given written scenarios, correctly differentiate between situations that describe and actual exacerbation of mental illness symptoms and situations that describe a situational behavioral response.

CLASS THREE: Recognizing Antecedents

Staff will demonstrate understanding of antecedent conditions and/or behaviors as demonstrated by identifying an antecedent behavior and/or and environmental trigger demonstrated in a role play scenario, and suggest staff response and support for the consumer at that time.

Staff will effectively work in a group and participate in a role play scenario in the part of staff offering focused support to a consumer who is experiencing an identified antecedent behavior. Staff will effectively work in a group and participate in a role play scenario in the part of a consumer who is experiencing anxiety and agitation.

Staff will identify 5 environmental influences that may influence everyone's behavior as environmental triggers.

Staff will identify two environmental influences that act as personal environmental triggers.

Staff will identify at least three effective staff responses at the antecedent stage.

Staff will identify that the goal of staff support when an antecedent behavior (or situation) is present is to reduce anxiety.

CLASS FOUR: Avoiding Physical and Chemical Restraints

Staff will identify that mediator analysis (self monitoring) is necessary in supporting consumers who are experiencing anxiety or a building crisis. Staff will identify five environmental influences that may affect their own behavior when supporting a consumer.

Staff will identify the two components of non verbal communication as personal space and body posture and motion.

Staff will recognize that para verbal communication is 'how we say what we say' which includes our tone, volume and rate of speech.

Staff will participate in role play situations practicing non-confrontive non verbal communication techniques (body movement, posture and personal space) and supportive para verbal communication techniques (voice tone, volume and rhythm) with a person who is agitated and making loud verbalizations.

CLASS FIVE: Diffusing Aggressive Behavior in the Home and Community

Staff will identify four often seen stages of escalating behavior in a developing crisis. Staff will identify an effective staff response at each stage.

Staff will practice active listening and support strategies in a role play with a consumer who is experiencing anxiety.

Staff will practice in role play situations appropriate limit setting directions and rational responses with consumers who are exhibiting defensive level behaviors (name calling, personal degrading remarks alluding to weight, race, sex and other verbal affront) directed at the specific staff.

Staff will practice in role play situations appropriate responses and defensive self protective moves to deflect physical aggression from a person who is physically acting out. Staff will practice defensive geographical strategies.

CLASS SIX: Life after a 5150; Making a Successful New Start

Staff will understand the importance for everyone of knowing they have a home to return to. Staff will understand the need to anticipate and plan for the consumer's return, at any time of day or night, from the time they leave for the hospital.

Staff will demonstrate through participation in activities and written responses strategies, techniques and responses used to reestablish relationships and rapport with consumers who are returning home after hospitalization.

PRESENTATION NOTES

CLASS ONE SLIDE NOTES

Slides 1-5: These slides introduce and define the terms value systems and cultural awareness. Slide 4 presents the socialization process as the vehicle through which the values of a group are learned.

Any number of examples drawn from the presenter's general experiences with family, school and church groups can be used to highlight the concepts,. It is likely that the group will identify many common experiences.

The group may be asked whether they identify the moral view of disability in these statements referencing people who have disabilities: "We are all God's children" and " They are closer to God"

"We are all God's children" reflects inclusion in the larger group, and that inclusion is not based on the disability; "They are closer to God" reflects that a person has special standing as a function of the disability, which reflects the moral view of disability.

Any number of examples from everyday life may be used to explain what is meant by 'social skills appropriate to our social position'. One example is a discussion of the knowledge, or lack of knowledge, of the placement and order of use of flatware in a formal table setting.

Most people who are members of the middle class in the United States do not acquire this knowledge only through their socialization process, because more casual dining is the norm in middle class households. Conversely, in upper class households, formal dining is encountered in the home setting frequently, and children learn this because it is part of their ongoing social experience. The example can be broadened to include many specific social behaviors that we learn through interaction with our families and school peers, but that are absent from the experiences of a person who grows up in an institutional setting. The conversation should include that the socialization process affects not only beliefs and values, but also our overt attitudes. The discussion of attitudes provides a segue to the views and attitudes of our society and culture toward disability.

Slide 6: Introduces the question of how our primary culture views disability. A broad definition of disability is provided that defines a disability as anything that puts an individual at a disadvantage, resulting in a lack of power or strength.

The strength and power referenced are not physical but social strength and power.

Slide 7: The most salient discussion point is that the Moral View is the most prevalent view of disability, across cultures, and through history, and that we are all socialized with the moral view of disability.

The point is to identify the typically harmful influences of the moral view, rather than demonize the moral view, and that the Civil Rights view is the only view that is actually based in the reality of equality.

The influence of the moral view is seen throughout our culture, resulting in people who have disabilities being treated differently because they are believed to be morally different, often spiritually better. We have been socialized with the moral view of disability ingrained in our experience. The term 'special' has become almost synonymous with disability, as in 'special education' and 'special Olympics' or 'special souls'.

Class members may have difficulty identifying the moral view of disability that results from the extension of charity toward those who have a disability by many organized religions.

In the discussion of the Civil Rights View, it is important to include in the discussion that people who have a disability represent a social minority and because they are a social minority they need either to advocate for themselves or receive advocacy on their behalf in order to receive fair and equal treatment in society.

Slide 8: Slide 8 precedes the audio presentation with a definition and discussion of social inclusion, including the risks and detriments of segregation. Full Inclusion is included and discussed here to highlight that social segregation is a pervasive effect of the Moral View to which we have all been socialized. Full social inclusion is the opposite of segregation. Utilize the examples provided earlier in the class for examination.

The instructor may solicit class members to relate any divergent social or cultural histories that resulted in childhood socialization that included the belief in the Civil Rights View of disability

Slides 9-14: These slides accompany the audio "What is the Moral View of Disability" from "Saints and Sinners: The Moral View of Disability.

Slide 15: The History Cards are photographs and artistic renderings depicting scenes from 350 B.C. through present day that reflect the influence of the Moral View of disability. Each table can be assigned two History Cards to discuss, answer the questions and then present their cards and responses to the larger group.

Slides 16-18: Changing Attitudes are video vignettes depicting scenes played by actors in the ACT Theater group. After viewing both vignettes, the groups work together to record their responses to the displayed questions. The formal questions may be omitted at the discretion of the facilitator if it seems that the groups are responding to the questions literally to the extent that the point of reflection and analysis is lost. In that case, groups may be requested to share their reactions more informally . They may be asked to share how they felt while they watched, or how they thought the participants felt. Groups then choose how to present their conclusions to the larger group, and do so.

Slide 19: This slide is presented and displayed while the students in their small groups read short dialogues of everyday situations where one of the participants reflects the Moral View of disability. They are asked to identify the influence of the Moral View in what the person said, and take the part in the dialogue of the person who hears the Moral View being shared. The dialogue is rewritten with the participant responding to the Moral View in a way that shares the reality of the Civil Rights View of disability. After working in their groups, each group presents their rewritten dialogue(s) to the larger group. They may choose one person to read, or they may choose two people to engage in the altered dialogue.

Slide 20: A review of the need to engage in ongoing mediator analysis-being aware of our beliefs and values, our biases, in order to be as objective as possible in providing support to the consumers we serve. Introduce the course themes of Behavior Changes Behavior and Every Interaction is an Integrated Experience.

CLASS TWO SLIDE NOTES

Slide2: Symptoms of mental illness are communicated differently by people who have developmental disabilities. Once identified and treated, their functioning is very different.

Slide 3: The presence of mental illness not only affects the people who have the mental illness, but the lives of the people around them. In the following slides, we will discuss the ways to assess for mental illness , treatment options and the goals of treatment.

Slide 5: Here we see some of the statistics of mental illness in the general population

Slide 6: There is a tendency to see issues as behavioral problems, rather than to consider the possibility of an underlying mental illness.

Slide 10: Professionals are typically not comfortable when the patient is not able to explain what is happening to them.

Slide 12: There is an historic tug of war between the mental health system and the regional center system.

Slide 13: Generally speaking, patients who have a developmental disability often have multiple medical problems and are on multiple medications for those medical problems. Many consumers go from placement to placement and there is no consistent bonding with others. All this leads to higher stress and increased risk for depression and anxiety.

Slide 14: This is some of the important information to have for the physician to review at the consumer's appointment. It will help the physician understand the consumer's condition and avoid repeating tests.

Slide 15: Persons who know the patient best can provide the most detail of the patient's current issues. It is important to report any changes: when they occur, how they occur, medication changes, changes in family, caretaker etc. are all important for the physician to know.

Slide 17: Patients who have chronic medical conditions have a higher prevalence of depression.

Slide 18: Complaints of chronic unexplained pain increases the chances that a person might be experiencing depression.

Slide 19: There is a higher incidence of depression among people who have a chronic medical condition.

Slide 20: These are some of the symptoms required to make the diagnosis.

Slide 21: When a depression diagnosis is missed or not treated, it affects the person's quality of life. There is a significant risk of suicide.

Slide 22: If there is an organic cause for depression, it should be treated first.

Slide 24: These are some of the things that could lead to an increased risk for depression.

Slide 25: A patient needs to be treated at an adequate dose for the right length of time before considering that the medication was not effective.

Slide 26: Medications have side effects and require regular monitoring for risk and benefit assessment.

Slide 27: These are some of the things to consider prior to choosing the medication.

Slide 28: This is a chart with some of the typical medication doses and a profile of the side effects.

Slide 29: Some of the side effects of tricyclic antidepressants.

Slide 30: Typical doses and side effect profile for a newer class of antidepressant medications.

Slide 31: Some of the typical side effects of the SSRI antidepressants.

Slide 32: This is the ideal treatment recommendation for the treatment of depression.

Slide 33: These are the issues to be considered for length of treatment.

Slide 37: These are the different types of schizophrenia.

Slide 38: If any of these conditions causes psychosis, the primary condition should be treated first.

Slide 40: These are some of the ways that people who have schizophrenia present themselves.

Slide 41: Schizophrenia affects cognition, and there is a higher risk of suicide.

Slide 43: Schizophrenia is a very serious and chronic illness.

Slide 44: This slide shows some places that have a higher incidence of schizophrenia.

Slide 45: This is the ideal long term treatment strategy.

Slide 47: These are the dose ranges for the older type of medications.

Slide 48: Dose range for the newer type of medications.

Slide 49: This slide shows some of the side effects for which the patient should get evaluated and monitored.

Slide 50: Side effects that require regular monitoring.

Slide 51: These side effects are specific to Mellaril.

Slide 52: This is specific to Thorazine

Slide 53: These medications are given as injectibles once or twice per month.

Slide 58: Patients who take Mellaril require regular EKG monitoring.

Slide 59: These medications can affect the heart rhythm and should not be combined.

Slide 60: There is an increased risk for increased heart rhythm if combined with Mellaril.

Slide 61: These factors contribute to an increased risk for irregular heart rhythm.

Slide 63: Patients on these medications need to have regular monitoring of fasting blood sugar and lipid profile.

Slide 71: A demographic of bipolar illness.

Slide 72: Illness is often not diagnosed early enough.

Slide 73: This is a chronic condition that needs to be treated adequately.

Slide 75: This illness has a higher risk of suicide.

Slide 76: These are some of the symptoms of the manic phase of bipolar illness

Slide 77: These are some of the symptoms of the depressive phase of bipolar illness.

Slide 84: These are some additional things to look for that are associated with mania

Slide 85: Many patients have psychotic symptoms

Slide 87: These are some of the symptoms for the diagnosis

Slide 89: These are some risk factors

Slide 91: Again, taking a good history is so important

Slide 96: These are some of the treatment options

Slide 98: Some of the side effects of Lithium require regular monitoring

Slide 100: Here are some of the side effects that need monitoring for this medication

Slide 101: Some of the medication might get affected when taking Tegretol.

Slide 102: Antipsychotics are commonly used to treat acute mania.

Slide 103: Some of the side effects of antipsychotics

Slide 107: Unless warranted by side effects, medication should not be discontinued abruptly.

CLASS THREE SLIDE NOTES and PRESENTATION COMMENTARY

Slide 2: A good way to remember that an antecedent is what comes before is to think about our anatomy with our posterior being our rear and our anterior being our front. Ante- means in front of. So, and antecedent is something that 'is in front of' or comes before something else. For our purposes, we discuss antecedent behavior and antecedent situations. An antecedent behavior is something that a person does that typically signals that anxiety is building, or they are feeling stressed. The benefit of recognizing these small signals is that we have an opportunity to "get out in front of" a behavioral escalation and prevent it if we can help relieve the anxiety when we see signs of it. We don't always have this opportunity, but we often do and it is important to observe and keep a record of what we find out about a person, and how they react in many situations.

Which brings us to antecedent situations. These are environmental situations that 'set us up' for having a difficult time with our self control. We all have them. For some of us it might be physically crowded rooms, for others of us it could be the noise level, or the temperature. We find these things out about a person through our observations. The benefit of knowing a person's antecedent situations is that we can help a person prepare for them, anticipate them and make some adjustments so that they can maintain their self control. Along the way to that outcome, while we are helping the person learn and use coping skills, we can use our knowledge of the situations that are problematic for a person and make the adjustments to their environment so that it is a 'better fit' for them . In other words, we set the stage for success!

While the terms are similar, setting event is typically used to refer to something that has occurred, but is not immediate. Typically a setting event is used to refer to something that has occurred in the past, for example, a death of a loved one. Behavior trigger is typically used to refer to a more immediate situation. For example, if I'm working as fast as I can and you walk up to me and say "speed it up' , your comment may well be the trigger for me to engage in my target behavior of punching with a closed fist.

There are a number of general environmental factors that can act a situational antecedents for all of us. To go back to the example we just cited, it could be that I get very stressed in a number of social situations where I am trying to meet the expectations of others. That would be my situational antecedent, and your 'speed it up' comment is in that category of situations and acted as a trigger for my punching behavior. We will talk more about this not only in this class, but as we progress through Classes 3 through 6.

Slide 3: We need to make an important distinction. Many of us use the term 'behavior' to mean something negative, as in "and then he had a behavior". I have heard people say things such as, "I have a high behavior home". Well, my goodness, I say, so do I. I have always found funeral homes a little too dead! Get it? Funeral homes (unless the staff is there) have no behavior because everybody is dead!

One rule of behavior: We must have behavior to be alive. Behavior is all that we say and all that we do. It is our observable activity. So, our behavior itself is neither 'good' nor 'bad' or 'appropriate' or 'inappropriate'. Whether or not a behavior is appropriate or inappropriate is situational. It is important to remember that when we look across all cultures, and all societies, there is no behavior that is universally considered inappropriate. Appropriateness is determined by the social context. Going back to our first class, within our larger culture we have smaller cultural groups that influence our determination of whether something is appropriate or not. To help us be as objective as possible in supporting consumers in achieving their chosen life quality outcomes, it is even more useful to consumers to view behavior from whether it is socially significant for them, rather than assigning 'appropriateness 'or 'inappropriateness '. The amount of social significance of a behavior for a person is the extent to which it supports them in achieving their desires.

For example, lets say that Bob has identified that he wants to work at a job with a competitive wage and live in his own apartment. Currently, he exhibits what many call a 'bad temper'. When he becomes frustrated he throws objects with little regard for where they land, or he punches walls and kicks doors and windows while yelling obscenities. This behavior occurs both on the job at the supported employment site and at home. This throwing, punching and kicking behavior has a very low social significance for Bob in terms of helping him achieve his preferred future. A behavior that would have a high social significance for Bob though would be to take a deep breath when he is becoming frustrated, set down any object in his hand and walk away to take a 'breather'. This would be positively significant in helping him maintain a job, and it also would not contribute to being evicted from an apartment living situation.

Our behavior fits into 4 main categories. Let's take a look at them. Can anyone think of a behavior that they think would not fall under either Escape, Attention, Sensory or Tangible Outcome? Let's try.

How many people agree with this statement: "A person must be able to say at least one word in order to communicate." (Display Slide 4)

What percent of our communication is accomplished without us ever uttering a word? Look at that! A whopping 58%. More than half of what we say we say through our bodies. That is really powerful.

What is para verbal communication? A good way to remember that is 'how we say what we say' (Instructor: say the same words using different inflections such as "do you need help" "what did you say" etc. to emphasize the point) This accounts for another 35% of our communication. Which leaves only 7% to the actual words that we use.

Slide 5: Let's take a closer look at what our non verbal communication actually is. It is what we do with our bodies. It has three components: how we move, how we hold ourselves and where we place ourselves. This is very basic, but something that we must practice, practice, practice so that when we need it most, when we are stressed, we will default into the message that we want to send, one of support, and not one of defensiveness.

What do we mean by that? When we enter a stressful situation (providing support to someone who is stressed is stressful) we are working, often unconsciously, to control our rising stress. Unfortunately, many of the things that we do to calm ourselves are often communicated as defensiveness.

For example, many of us tend to fold our arms across our chests (almost giving ourselves a hug) approach more quickly than we realize and stand too close to the person who is already stressed. This can contribute to a person feeling boxed in and trapped. We want to be sure that we give a person enough space and stand at an angle to them. Standing at an angle achieves two things: it gives the person an outlet and it leaves us in a position to be able to step back and away while maintaining our balance if the person attempts to strike or kick us.

We want to monitor our facial expressions to make sure that we are not frowning, because that would not deliver a message of support. Again, these things are basic but fundamentally important, and should be practiced constantly when we are relaxed so that we will default into them when we are stressed.

Let's do some practice exercises. Let's line up across from each other and on my signal the row on my right will approach the person directly across from them. The people in the line on my left who are being approached will hold up their hand when they want the person to stop because any closer and they would not be comfortable.

(complete the exercise) OK. Now before we move, let's look down the line. With a couple of exceptions where someone has a smaller or greater personal space area, people have stopped about 2 feet from the person they approached.

Now, on my direction, the people who approached please take a step toward the person, then a large step back and to the left so that you are standing at an angle to the person.

(instructor demonstrate first)

OK. Let's talk about how that feels. Those of you who were approached, does it feel different to you when the person steps away from you and stands at an angle? How?

Slide 7: Now we see the environmental factors that can act as situational antecedents. In this list, does anyone identify any of these environmental factors that 'set them up" or 'set the stage' for them to have some difficulty or to struggle with their self control?

Remember, the great value in knowing each consumer's situational antecedents is that if we can predict, we can probably prevent. We can use this knowledge to modify the environment to be a better fit for the consumer.

While we have mentioned modification, it is another important distinction to understand that we are not modifying another persons behavior. Our job is to make environmental modifications to make it easier for the person to better manage their own behavior.

Rhetoric is powerful, and how we look at something really does change how we see it.

Slide 9: These environmental modifications are called antecedent control strategies. Does that make sense to everyone? We can make an environmental modification for just about everything; we often really have to think outside the box. But it is a crucially important part of 'being out ahead' of a behavioral escalation. You might look at it this way also: we can either get out in front of a behavior, or we can chase it. And if we find ourselves chasing it, we are more than likely a part of the problem.

Let's start with Removing Seductive Objects. Any number of things might function as seductive objects. If we know John eats coins, what a set up for failure to keep the loose coin jar out in the open on the fireplace mantel. A simple environmental modification (antecedent control strategy) is to place that coin jar behind a cupboard door; out of sight but still easy to throw loose change into.

Remove Unnecessary Demands and Requests Many of us have some control issues, so this can be a difficult concept, but we really need to let go of 'because I said so, and I'm in charge here'. Whenever we make a request of a consumer, the first question we need to ask ourselves is just how important is it that they comply, and that they do it right now? Actually, we need to do this self assessment before we make a request, an imposition, on the consumer. We need to take stock of the environment and be respectful of their priorities. We may think their TV viewing choice of Monday Night RAW is of no value, so we will interrupt them in the middle of it with a request. If they throw the remote at us, we need to take responsibility for having just provided the antecedent situation that set them up for that behavior. With a little careful consideration and respect for their choice, we could set them up for success and get our request made during a commercial, or at the end of the show.

Eliminate Provocative Statements and Actions We need to have an ongoing self assessment to monitor how what we say comes across. This is part of that "trigger guard" that we must have in place, and in order

to have that available, we must be in touch with what our own behavioral triggers are. Getting staff off the track with some provocation often serves a couple purposes for the consumers, it can be entertaining to 'bait' the staff and it keeps them from doing the hard work of addressing their own issues.

Slides 10-12: We want to be a supportive non judgmental presence. It is important to acknowledge what we see; reflect it back to the person. It is OK to help a person solve their problem if that will help them out of the situation while they maintain their dignity, and are spared a behavioral escalation. Even if someone is capable of doing something themselves, when they are struggling is not the time to try to worry about the possibility that you might be contributing to their dependence on you. Help them out if that will help them maintain their control at that moment. Then, when they are relaxed and available you can talk about what happened and review limits.

Offering Redirection will vary based on the individual. What works for one person may not be effective, or may even be counter productive for another. Using Positive Program Reminders and Self-Monitoring Instructions can be very effective. However, they need to be in place as part of an overall positive support plan in order to be available to use when they are needed as incentive reminders to either 'stay on track' or 'get back on track."

Of course, the examples on the last slide are just that. We certainly would not want to bombard someone by asking this series of questions.

Now we are going to have the opportunity to act out some role plays.

It is important to understand that often what the staff does in a situation actually becomes the antecedent situation or behavioral trigger for the consumer's target behavioral response. These role plays are dramatized to help us see how a change in our behavior (how we respond) can and does have a significant effect on the consumer's behavior. We can significantly affect the outcome by changing our responses and setting the stage for success. Behavior Changes Behavior!

Is everyone ready to have some fun? Lets get started!

Each table will have one role play. Read it either together or individually. Discuss what happened.

Identify any situational antecedents, behavioral antecedents or behavior triggers and how you would make an environmental modification to support the consumer for a different outcome. What things would you do differently?

Rewrite the interaction based on what you would do. You may find that your rewrite is much shorter than the original.

We will take about 15 minutes to work on these. I will walk around to each table to make sure everyone's questions are answered. When you finish, you will take turns presenting the play as it was originally written.

Then, you will explain what you would do differently, when and how, Then, you will present your rewritten interaction. Remember, your rewrite may be much shorter than the original.

We will be watching for your non verbal communication. Our 'director' may stop the action to point out some things that you are doing. It could be to draw the audience's attention to something you are doing really well, or something you could try a different way. So, just because the action has been stopped does not mean that you have done something "wrong".

For example, if you are approaching the consumer with your hands in your pockets, the director may stop the action to point that out to you. Also, if you are standing at an angle to the consumer and speaking to them, the director may stop the action to point out how your stance provides the person a physical and psychological outlet, provides you a balanced position from which to pivot away from a strike and respects the person's personal space.

Remember, this is a great opportunity to receive some on the job coaching. When one group is presenting, the rest of us are the supportive presence for those individuals and need to monitor our reactions to maintain that supportive presence.

Instructor Note: Participants are identifying in this exercise antecedent situations, antecedent behaviors and environmental modifications that they can implement to make the environment a 'better fit' for the consumer, thereby helping the consumer maintain or regain their self control. These role plays specifically focus on how DSP behavior contributes to the outcome of an interaction, either helping the consumer maintain/regain self control, or contributing to a situational decompensation.

One point that should be emphasized here, and throughout the curriculum, is that the terms 'management' and 'modification' are applied to changes staff can make to the environment, rather than the consumer or the consumer's behavior. By effectively managing or modifying the environment that 'surrounds' a behavior, DSP can help the consumer better manage their own behavior.

CLASSES FOUR and FIVE PRESENTATION NOTES

Classes 4 and 5 do not have Power Point presentations. Class 4 begins with a review of the Class 3 content of presenting a supportive presence. Review content of Class 3 Slides 10-12.

The 'rules of engagement' remain the same as in Class 3, and continue for the remainder of the course. The entire class is the supportive presence for the individuals or group presenting.

Class 4 introduces the Facilitator/Mediator Guide which presents the CPI Non Violent Crisis Intervention behavior escalation continuum. This functions essentially as a review and reminder since some form of crisis intervention training is required by IRC in ARM level 4 homes. Crisis Prevention Institute's Non Violent Crisis Intervention is the training completed by the majority of the IRC vendors, so this curriculum utilizes that familiar terminology and structure.

The term Mediator Guide is used to reemphasize the fact that staff function in the role of mediator, that every interaction is an integrated experience.

Accompanying the Mediator Guide are instructions for participants who will play the roles of consumers in 7 vignettes which correspond to the stages on the behavior escalation continuum beginning with experiencing/exhibiting anxiety and concluding with tension reduction. This should be similar to an exercise that many have encountered previously in CPI training.

Some participants will be assigned the role of staff, and some participants will be assigned the roles of consumers.

The staff are instructed to approach the consumer and make a request of them; some commonplace request that they might ask of the person on a typical day. They are told that the consumer will respond in one of the stages of the behavioral escalation continuum. They are asked to provide the type of support that would be most effective for what the consumer is experiencing at that moment. The consumer also might be expressing anxiety when the staff approaches. In that instance, the staff would be expected to abandon their intended request and acknowledge what they see, and attempt to relieve the anxiety. The participants are told that the 'director' may stop the action at any time to point out or comment on the staff's technique.

The participants who are playing the roles of the consumers will each be assigned a specific response from the continuum. Staff may work in their groups to review the behavior category/staff response guides prior to beginning the exercise.

When the exercise begins, it is helpful to stop the action with the first one or two participants right after the consumer makes their first response to the staff's request. This will support the participants with a reminder of what the consumer is experiencing and quickly review what is an effective staff response at that time.

The state of relaxation is omitted from the vignettes. If someone does not recognize this, it will be necessary to point it out, and review the behavior category of a state of relaxation. If time permits, volunteers may be sought to play the roles of a consumer feeling relaxed and a staff who is going to make a request of him. The object is to emphasize that when we are relaxed we are emotionally available, and it is our best time to learn new things and to problem solve.

Class 4 concludes with three role plays. Classes 4 and 5 include situations between and among consumers that have already escalated, and the staff must enter an existing 'crisis' situation. The plays may be utilized in several ways depending upon the group. In the pilot project, each small group was assigned a play. They read it as it was written, noted what they thought had happened in the interaction, and why, and what they would do differently, and why.

Then they rewrote the play with the goal of achieving the outcome of helping the consumer resolve the situation by either maintaining or regaining their self control, and preserving their dignity. Within that framework, they are recognizing anxiety and attempting to relieve it when they saw it, offering the consumer options and control, and genuinely listening and hearing what the consumer is communicating.

Participants are again reminded that their rewrite may be much shorter than the original play. They can be asked why this would be. It can be used as an opportunity to reiterate that for the most part as originally written, the DSP response contributes to the consumer's escalation, rather than helping resolve the situation.

Participants chose among themselves who would play the role of staff in presenting their play. Each group then presented their play twice. First, as it was originally written, and then their rewrite.

The audience is reminded that they are the supportive presence for the actors, and they are instructed to make notes of what the DSP is doing and saying, and when they would do something different.

In these role plays, the participants play only the role of DSP, with the instructor or assistants playing the roles of the consumers. This is done to better control the responses the consumers make to the staff approaches. See the consumer instructions of the vignette guide for further discussion of this point.

CLASS 6 PRESENTATION NOTES

Class 6 consists of a series of 14 thoughts for interaction and commentary by the class followed by a Power Point presentation. This guide provides instructor commentary for the thoughts.

Thought 1: The consumers that we work with generally come from family or residential situations where often there is violence and aggression. Most importantly, expressions of love may have been minimal. Therefore, life does not connote a positive meaning for them. It is part of our job to teach them and show them that life can be good. It is up to us to demonstrate this to them through our own behaviors toward them.

Thought 2: Yes, a change in lifestyle will impact a change in behavior. If a consumer that has experienced abuse or rejection is then placed in an environment where they are able to experience the opposite, then a change through lifestyle will occur. This new lifestyle which is supportive to the consumer's mental and physical health would definitely impact a change in lifestyle.

Thought 3: We perceive our lives based upon our past upbringing, our experiences in life and the way we view ourselves. Is the way we view ourselves how others see us? We need to constantly be learning how we are really perceived by others and not be limited by the way in which we see ourselves. In other words, we usually have biased perceptions of ourselves.

Thought 4: This is called 'active listening'. It simply means that we don't just hear what is being said to us, but we also listen with our hearts in a manner that is open and understanding of an individual's 'personal pain' ; how they feel and as they would like to be understood.

Thought 5: People need to feel that they are valued as individuals. They need to feel that they are important and that there is someone in the world that can understand how they feel. Unconditional Positive Regard provides unconditional understanding, love and total commitment toward an individual who is reaching out for help. Unconditional Positive Regard provides for reaching out and actually feeling a person's pain and bonding with that individual in a manner that is supportive, non judgmental, consistent, active and constant despite any setbacks that might occur. We don't give up on the consumers we serve, just as we would not give up on family.

Thought 6: We can actually assist the consumers to begin questioning their belief systems by having them test and challenge the beliefs. For example, the statement 'everyone hates me" could be challenged by referring to the fact that you are talking to them and you do not hate them. Of course, this is a simplistic example, but most false belief systems can be tested, and clarified through repetitive reality testing and clarification of the inaccurate perception.

Thought 7: As we help the consumers progress through more accurate interpretations of their beliefs, we also provide a supportive presence and continually help with the accurate interpretations and testing of how they see their world as opposed to what their world actually now is.

Thought 8: By assisting consumers to take a risk and take small steps in changing their perceptions that are biased and erroneous, we can enable them to take calculated risks that will eventually change the way they think and allow for more accurate thinking patterns that are based on reality and not self defeating behaviors.

Thought 9: When we have become familiar with the consumer's pain and their world we are now being genuine with them. By being genuine with the consumer, we are now relating in a manner that is respectful and real for the consumer. It is at this point where positive change will likely occur.

Thought 10: Do your children believe in you, and do you believe in your children? How do you support your children emotionally? How would you use this analogy in responding to how you would treat consumers to affect positive change?

Thought 11: Please think about the world of the consumers and where they come from and respond to this question. Generally speaking, many of the consumers we serve have had emotionally and experientially impoverished histories. How do you think this has would impact them? Generally speaking, this type of experience leads children to become very distrusting, angry or depressed. It is therefore up to us as role models to understand their world and to relate to them in a manner that will allow them to become the best person they can be: self actualized.

Thought 12: Again, it is important to understand the world of the consumer so that we can relate to them in a responsible manner. That means be aware of their background, their behavior patterns, their basic perceptions of how they view their life. It is important to also be supportive of their belief systems while allowing them the opportunity to take small risks that will lead to positive change and stability in their lives.

Thought 13: When we are young our parents may tell us that we are not smart enough, that we are too slow or too fat etc. Unfortunately, these thoughts can repeat and can recur through our lives. Without any kind of reality testing this thought can become our reality causing us unnecessary strife through life. It is therefore important to challenge the consumers we serve on an ongoing basis so that they can learn how to control automatic thoughts that are self defeating.

Demonstrate that there are other ways to handle our feelings. Challenge the false beliefs in a manner that supports a positive outcome for the consumer. This is really a sales job that entails your investment and commitment to helping the consumer.

CURRICULUM RESOURCE LIST

Tools for Change: "Changing Attitudes " Workbook and DVD featuring the Interact Theatre Company and "Saints, Sinners and Special People" – Understanding the Moral View of Disability from

ACT Advocating Change Together Self Advocacy Resource Network 1821 University Avenue West Suite 306S St. Paul, MN 55104 (DVD)

The Principles and Practices of Building Community presented by

Dr. Thomas Pomeranz; produced by Tierra Del Sol and Universal

LifeStiles L.L.C. (DVD)

The Vision Library for Enhancing Quality of Life developed by

Dr. Thomas Pomeranz; produced by Universal LifeStiles L.L.C. (DVD)

Competency Based Training Curriculum by Julia F. Shaull, M.S.W.;

Gary W. Lavigna, Ph.D; Thomas J. Willis, PhD. Published by the Institute for Applied Behavior Analysis 5777 West Century Blvd., Suite #675

Los Angeles, CA 90045 (available by contacting IABA) (DVD)

Managing Threatening Confrontations by Paul White Published by Attainment Company Inc. PO Box 930160 Verona, WI 53593 (DVD)

Supporting Self-Determination-Strategies for Direct Support Staff authored by Elizabeth Thorin, Ph.D. Produced by IRIS Media, Inc. Eugene OR (VCR)

Applied Behavior Analysis second edition by John O. Cooper; Timothy E. Heron; William L. Heward published by Pearson Merrill Prentice Hall (book)

Elementary Principles of Behavior by Richard W. Malott and Donald L. Whaley published by Appleton Century Crofts (book)

Teaching Anger Management from Monaco and Associates distributed by Program Development Associates (DVD)

Dealing with Challenging Behavior-Positive approaches to behavior change in community settings from Synchrony Training Solutions developed in collaboration with the North Shore Assoc. for Retarded Citizens (DVD)

Self Determination-Tools for Direct Support Staff IRIS Media, Inc. 258 E. 10th Ave. Suite B Eugene OR 97401 (VCR)

Putting Self Determination into Practice and How to Make it Work an Irene M. Ward and Associates Production distributed by PDA (VCR)

Progress Without Punishment – Effective Approaches for Learners with Behavior Problems by Anne M. Donnellan; Gary W. LaVigna;

Nanette Negri-Shoultz and Lynette L. Fassbender published by Teacher's College Press Columbia University New York (book)

Social Skills Training for Psychiatric Patients by Robert Paul Liberman;

William J. DeRisi and Kim T. Mueser Psychology Practioner Guidebooks

Published by Allyn and Bacon Boston (book)

Relaxation – A comprehensive manual for adults, children and children with special needs by Joseph R. Cautela and June Groden published by Research Press Company Champaign IL 61822 (book)

The Periodic Service Review-A total Quality Assurance system for Human Services and Education by Gary W. LaVigna; Thomas J. Willis;

Julia F. Shaull; Maryam Abedi and Melissa Sweitzer published by Paul H. Brookes Publishing Baltimore (book)

Psychotropic Medications in Persons with Developmental Disabilities by

Bryan H. King, M.D. published by Frank D. Lanterman Regional Center